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8 **BEFORE THE**
BOARD OF REGISTERED NURSING
9 **DEPARTMENT OF CONSUMER AFFAIRS**
STATE OF CALIFORNIA

10 In the Matter of the Accusation Against:

Case No. **2010-479**

11 RICHARD OLIVEIRA

12 5329 Cherry Ridge Drive
13 Camarillo, CA 93012

ACCUSATION

14 931 Panther Lane
15 Allen, Texas 75013

16 Registered Nurse License No. RN 576729

17 Respondent.
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20 Complainant alleges:

21 **PARTIES**

22 1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her
23 official capacity as the Interim Executive Officer of the Board of Registered Nursing (Board),
24 Department of Consumer Affairs.

25 2. On or about January 31, 2001, the Board issued Registered Nurse License Number
26 RN 576729 to Richard Oliveira (Respondent). The Registered Nurse License was in full force
27 and effect at all times relevant to the charges brought herein and expired on September 30, 2006.
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JURISDICTION

3. This Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Code provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act (§ 2700 et seq.).

5. Section 2761 of the Code states, in pertinent part:

"The board may take disciplinary action against a . . . licensed nurse . . . for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual . . . licensed nursing functions."

6. California Code of Regulations, title 16, section 1442, states:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

7. California Code of Regulations, title 16, section 1443, states:

"As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

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8. California Code of Regulations, title 16, section 1443.5 states, in pertinent part:

“A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

• • • •

“(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family”

9. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

FACTUAL BACKGROUND

10. At all times relevant herein, Respondent was employed as a registered nurse by Dialysis-Stat Medical Group, Inc., of Simi Valley, California, a service which provided dialysis services to hospitalized patients.

11. On or about December 27, 2004, Respondent was the nurse for patient T.D., a 78-year-old female, undergoing dialysis for end stage renal disease, at Sherman Oaks Hospital.

12. At approximately 1800 hours, Respondent initiated treatment and charted patient T.D.'s vital signs, including blood pressure, heart rate, blood flow rate, UF (ultrafiltration) rate, venous pressure, arterial pressure, heparin and fluids. T.D. was Respondent's only assigned patient on the subject night.

13. Patient T.D.'s blanket was covering the dialysis access site (right vascular catheter). Respondent tried to explain to patient T.D. that he needed to see the catheter, but the patient did not speak English.

14. Respondent did not ask hospital staff for an interpreter or translator, or ask if any of patient T.D.'s family was present who could translate.

15. Respondent went on with the dialysis, even though he did not have a clear view at all times of the access site.

16. At approximately 1830 hours, Respondent adjusted the patient T.D.'s catheter as there were some catheter flow problems.

17. Between approximately 1940 and 2010 hours, Respondent believed he saw patient T.D. move.

18. At approximately 2010 hours, he went to the head of the bed, and noticed patient T.D.'s face was pale. He lifted the blanket and noted the catheter was dislodged. He moved her hand and the catheter fell out. He noticed a pool of blood on the bed. He applied pressure at the site. The bleeding did not stop.

19. He went to the door and called for help and when he came back he saw blood on the floor. Other nurses came to the room, assessed the patient, and called a code when they could not get a pulse.

20. Patient T.D. became hemodynamically unstable and was unable to be resuscitated. She died on December 28, 2004.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

21. Respondent is subject to disciplinary action under Code section 2761, subdivision (a)(1), as defined under California Code of Regulations, title 16, section 1442, in that on or about December 27, 2004, while on duty as a registered nurse at Sherman Oaks Hospital, Respondent failed to exercise the standard of practice which, under similar circumstances, would have been exercised by a competent registered nurse, thereby causing or substantially contributing to the death of patient T.D., by failing to communicate vital information to patient T.D.; failing to maintain visible contact with patient T.D.'s catheter site throughout the entire dialysis procedure; and failing to notice when patient T.D.'s catheter became dislodged. Complainant refers to and by this reference incorporates the allegations set forth in paragraphs 10 through 20, above, as though set forth fully.

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1 SECOND CAUSE FOR DISCIPLINE

2 (Incompetence)

3 22. Respondent is subject to disciplinary action under Code section 2761, subdivision
4 (a)(1), as defined by California Code of Regulations, title 16, sections 1443 and 1443.5, in that on
5 or about December 27, 2004, Respondent demonstrated acts of incompetence. Complainant
6 refers to and by this reference incorporates the allegations set forth in paragraphs 10 through 20,
7 above, as though set forth fully.

8 PRAYER

9 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,
10 and that following the hearing, the Board of Registered Nursing issue a decision:

11 1. Revoking or suspending Registered Nurse License Number RN 576729, issued to
12 Respondent Richard Oliveira;

13 2. Ordering Respondent to pay the Board the reasonable costs of the investigation and
14 enforcement of this case, pursuant to Code section 125.3; and

15 3. Taking such other and further action as deemed necessary and proper.

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17 DATED: 3/29/10

Louise R. Bailey
LOUISE R. BAILEY, M.ED., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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